Questions from the Floor

Commonwealth Fund Investigations of Managed Care

Karen Davis

I'm going to open it up to question and answers, but before doing so, I would like to thank Humphrey Taylor, President of Louis Harris and Associates. Without him, we would not have been able to put together most of this information. Nearly all those surveys described in the preceding presentations were conducted by Louis Harris and Associates. May we have your questions?

Question from Irwin Redlenner (Montefiore Medical Center and the Children's Health Center)

I have two related questions. The first is that I'm concerned that surveying opinions of quality of service by either recipients of care or providers may be very inadequate ways of measuring either fee-for-service systems or capitated managed-care systems. I'm just concerned about what the baseline of comparison is. If Medicaid is part of the safety net system in our society, and that has bigger functions in a public health mission having to do with provision of quality services for underserved populations and poor populations, there are many other yardsticks which we need to understand.

The current system as it exists in most parts of the country has glaring inadequacies that began with and continue with fee-for-service arrangements, including very poor immunization rates among Medicaid populations, very, very spotty ability to track and monitor care of all sorts, and abuses of fee-for-service systems, from Medicaid mills to other types of problems with the system. So I'm not sure what we're comparing against. Do patient surveys of satisfaction really tell us all that much in relationship to whether

the system is solving the larger needs of getting kids into health care, care for people with chronic illnesses, etc.

A related question: where is the physician provider community in the decision-making process about where all this is going? Have we, as a profession, identified a role for ourselves that is filling a need in providing a reasonable amount of information to help guide where the system is going? I'm not sure what it is that we as health professionals are supposed to be doing about this to become even more serious players, rather than less serious players, as the system evolves in whichever way it's going.

Diane Rowland

In terms of Medicaid, I don't think anyone in this room or any of us would ever argue that the Medicaid system under fee for service has been perfect and without flaws, but what we've been trying to do with these surveys is not just measure patient satisfaction, but also measure other access utilization indicators to see whether there are differences between the uninsured, those with Medicaid fee for service, and those in Medicaid managed care.

Clearly, anywhere we look at the uninsured, they're worse off than anyone with Medicaid under either system. But I think there are real problems in any system with a low-income population in getting at some of the measures that you're concerned about, like immunizations and other access to care indicators.

One of the two other findings that I didn't talk about today that I think are particularly important is that, in California, we looked specifically at immunization rates and preventive care within the Medicaid population of those enrolled in managed care and those enrolled in fee for service. We found virtually no difference in those rates between the two systems. So I think it is another indicator that managed care needs a lot more than just to be implemented to make achievements.

The second study that particularly concerned me was that in looking at quality measures and outcome measures in three states, we asked plans in states like Minnesota and Ohio to be

able to use the HEDIS measures on their Medicaid population to give us some feedback on how well those populations were performing. What we discovered was that, in most of the plans that enrolled primarily Medicaid patients, they had no capacity to report back on any of the HEDIS measures, including things as basic as immunization or even disenrollment rates; it really required a plan that was already doing a lot of commercial business and familiar with HEDIS measures to be able to even comply with the most basic Medicaid measures. So I think it's just an indication of how far we have to go where any of these systems can provide the kind of access that meet some of our broad system goals.

Brian Biles

While patient-satisfaction indicators are a part of the measure of quality of the plan as a whole, obviously clinical care is very important as well. In that area we have information from a number of projects more directly in this area. One particularly we're working with is the National Committee for Quality Assurance (NCQA). Second, as part of our work with NCQA, people at Rand are working on the technical or clinical quality of care with some emphasis on low-income persons. Third, Dr. Arnold Epstein at Harvard is working to follow up on the query project, which is investigating ways for the states to develop techniques and administrative systems to measure both clinical and patient satisfaction, to build that into their systems and so to increase and improve the quality of care.

On the physician provider community, there are a number of physician leaders in managed care. We can obviously go back to Dr. Ernest Sayward, with Kaiser and the other plans. I think today we can certainly identify David Lawrence, who is the President of Kaiser and other plans as well. Physicians are playing a strong role as clinical leaders or as leaders of the plans, but it's a different group of physicians who have chosen a different career, perhaps, or emphasis for their activities.

Question from Susan Dorr (Gay Men's Health Crisis)

I must commend Commonwealth for its focus on issues in managed care for people with chronic illnesses and disabilities and indeed, commend the speakers today for their references to this population. I wonder whether any of the studies thus far have indicated how we may remove barriers to quality care and to improve satisfaction for people with chronic illnesses and disabilities in managed care, or whether the speed of enrollment projected by many states, New York among them, will outstrip our knowledge or how to serve this population in managed care.

Karen Davis

The most important way to ensure that people with chronic illness are satisfied with their care is to not disrupt the patterns of care that have become so crucial to them and to make sure that the providers in the networks that they get to choose, have adequate experience with those populations. We're particularly working now to try to develop some ways to look at how the AIDS population specifically is treated in managed care, how capitation rates are set, and what kinds of networks are important. I think it's very important that we work toward developing those kinds of standards and ways of assessing the adequacy of managed-care plans for populations with special needs.

Cathy Schoen

One of the things we're finding in these surveys, which really are snapshots of what's going on, is a clear problem, discontinuity of care, both in the employed and the Medicaid population. People are in and out. Another issue is to find ways that you can stay in your plan, if you get in a plan that works for you, but if you regroup all your relationships, you have a new set. Another issue that's come up is, what happens if the network really doesn't have what you need? We're starting to look at the kinds of innovations that are being done. States are just trying to find out what's being done, including omsbud programs or early alerts systems so people can obtain on an ongoing basis other support systems. I think

there's a long way to go on the list of safeguards because right now they have not been built in. A big part of that is that this is a new population for this industry that's moving in quite quickly.

Question from the Executive Director of Baily House (an Organization that Provides Housing and Services to People with AIDS)

I have two questions; anyone can answer.

What are the public policy implications as for-profit managed care really begins to grow and, therefore, one would expect that any cost savings realized in the system go directly to shareholders of those corporations, as opposed to going back into the not-for-profit service system? That's one question.

What as advocates can some of us begin to do in terms of talking to government about those public policy implications?

The other questions I have is, I have begun to realize recently that the public image of managed care formerly was that the physician was the gatekeeper. Both from personal experience and some other analysis, it seems to me the gatekeeper role has shifted from the physician to the insurance company.

Karen Davis

You've raised two important points. I don't think there's been a lot of work yet into looking at profit margins. The theory is that, over time, competition among plans would drive down high profits and those savings would be passed on to purchasers, meaning employers or the government, but I don't think there's a lot of work yet on that to see if that's working. I think what we are seeing is a lot of consolidation in the industry. There are about eleven national HMOs that have more than a million members that account for half of the HMO enrollment nationwide, so I think that's an important point as well.

Similarly, I think your perception of the gatekeepers shifting to the insurance company is true.

Question from Alfred Gelhorn

It has occurred to me that the various legislation that went on at the federal level and at the state level had thrown, particularly with regard to children, a large number, perhaps one-and-a-half million children, into the poverty level, and in the state of New York 400,000 have been thrown out of health care. In the various activities that this group or others are doing, are you looking at what happens with all of the situations not only for those who are in programs but out of programs?

Karen Davis

You were asking the question of what happens to those that are no longer in the Medicaid program. That's probably the most critical and important issue to be looking at over the coming years, to see what happens to those that haven't got access to care any longer with their insurance cards. We are trying to follow in seven states what happens not only to low-income people with Medicaid and insurance, but what happens to those who lose Medicaid coverage and to those that are uninsured. That's a critical issue because if you're in managed care or in fee-for-service Medicaid, you're still clearly better off than if you're uninsured, and we're now putting many millions of children at risk for losing insurance coverage as we change the welfare system and the Medicaid system.